ATTACHMENT 8
Sample Prior Authorization Request for Hearing Instrument and Audiological Services (PA/HIAS1)

DEPARTMENT OF HEALTH AND FAMILY SERVICES
Division of Health Care Financing
HCF 11020 (Rev. 06/03)

STATE OF WISCONSIN
HFS 106.03(4), Wis. Admin. Code

WISCONSIN MEDICAID

PRIOR AUTHORIZATION REQUEST FOR HEARING INSTRUMENT AND AUDIOLOGICAL SERVICES (PA/HIAS1)

Providers may submit prior authorization (PA) requests by fax to Wisconsin Medicaid at (608) 221-8616; or, providers may send the completed form with attachments to: Wisconsin Medicaid, Prior Authorization, Suite 88, 6406 Bridge Road, Madison, WI 53784-0088. **Instructions:** Type or print clearly. Before completing this form, read the instructions and information published in HCF 11020A.

FOR MEDICAID USE — ICN	AT	Prior Authorization Number

SECTION I — PROVIDER INFORMATION

1. Name and Address — Testing Center (Street, City, State, Zip Code)

Ima Testing Center
222 Oak Ave
Anytown, WI 55555

2. Telephone Number — Testing Center
(XXX) XXX-XXXX

3. Processing Type
123

3. Testing Center's Medicaid Provider Number
12345678

4. Name — Referring Physician
I.M. Referring

6. Referring Physician's UPIN, Medicaid, or License Number
X12345

SECTION II — RECIPIENT INFORMATION

7. Name and Address — Recipient (Last, First, Middle Initial; Street, City, State, Zip Code)

Recipient, Im A.
609 Willow
Anytown, WI 55555

8. Recipient Medicaid ID Number
1234567890

9. Sex — Recipient
☒ M
☐ F

10. Date of Birth — Recipient (MM/DD/YY)
MM/DD/YY

SECTION III — DIAGNOSIS / TREATMENT INFORMATION

11. Diagnosis — Code and Description **389.10 Sesnorineural Hearing Loss, Unspecified**

12. Performing Provider Number	13. Procedure Code	14. Modifiers 1	2	3	4	15. POS	16. Description of Service	17. QR	18. Charge
87654321	**V5252**					**11**	**Programmable Binaural ITE Aids**	**1**	**$XXX.XX**
87654321	**V5160**					**11**	**Binarual Dispensing Fee**	**1**	**$XXX.XX**

An approved authorization does not guarantee payment. Reimbursement is contingent upon eligibility of the recipient and provider at the time the service is provided and the completeness of the claim information. Payment will not be made for services initiated prior to approval or after the authorization expiration date. Reimbursement will be in accordance with Wisconsin Medicaid payment methodology and policy. If the recipient is enrolled in a Medicaid HMO at the time a prior authorized service is provided, Medicaid reimbursement will be allowed only if the service is not covered by the HMO.

19. **Total Charges** **$XXX.XX**

20. **SIGNATURE** — Requesting Provider I.M. Provider

21. Provider Type
☒ Audiologist
☐ Hearing Instrument Specialist

22. Date Signed
MM/DD/YY

FOR MEDICAID USE

Procedure(s) Authorized:

Quantity Authorized:

☐ Approved _____ Grant Date _____ Expiration Date

☐ Modified — Reason:

☐ Denied — Reason:

☐ Returned — Reason:

_____ **SIGNATURE** — Consultant / Analyst _____ Date Signed